No. 91-634

In The

Supreme Court of the United States

October Term, 1991

INDEPENDENT NURSING HOME ASSOCIATION and MISSISSIPPI HEALTH CARE ASSOCIATION,

Petitioners,

vs.

J. CLINTON SMITH, M.D., IN HIS OFFICIAL CAPACITY AS DIRECTOR OF THE STATE OF MISSISSIPPI DIVISION OF MEDICAID IN THE OFFICE OF THE GOVERNOR, and THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the Fifth Circuit Court of Appeals was correct in the factual determination that a 1984 state Medicaid plan amendment, made in response to a change in federal law, fell within the ambit of 42 C.F.R. §447.205(b)(1), thus exempting the amendment from the general public notice requirement for significant plan amendments governed by 42 C.F.R. §447.205(a)?

No federal or state constitutional or statutory questions are presented.

PARTIES TO THE PROCEEDING BELOW

The Parties To The Proceeding Below are correctly set forth in the Petition.

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OPINIONS BELOW, JURISDICTION, STATUTORY AND REGULATORY PROVISIONS INVOLVED

The Opinions Below, Jurisdiction and Statutory and Regulatory Provisions Involved are correctly set forth in the Petition.

STATEMENT OF THE CASE

Medicaid is a cooperative federal-state program of federal financial assistance to states to enable states to

provide medical assistance to needy individuals, 42 U.S.C. §§1396 et seq. As a prerequisite for receiving the federal subsidy, participating states must have a state plan – and any amendments thereto – approved by the federal Department of Health and Human Services acting through the Division of Health Care Financing Administration (HCFA), 42 U.S.C. §§1396a(a); 42 C.F.R. §430.10. The State of Mississippi, Division of Medicaid (DOM) participates in the federally assisted Medicaid program under a federally approved Long-Term Care Reimbursement Plan. Miss. Code Ann. §§43-13-101, et seq.

In mid-1984, Congress enacted the Deficit Reduction Act (DEFRA), §2314 of which substantively modified the federal requirements governing both the federal Medicare program, 42 U.S.C. §§1395 et seq., and the federally assisted Medicaid program, 42 U.S.C. §§1396 et seq. In the only relevant modification, DEFRA limited the amount of authorized Medicare and Medicaid payments on capital-related assets associated with the sale or transfer of a nursing home. Such limitation fell within two sub-categories: (1) Re-evaluation of Assets which involves calculation of the payment rate to the new owner based on an allowance for depreciation, interest and return on equity and (2) Recapture of Depreciation which involves recoupment of depreciation paid to the former owner.

As to Medicare, §2314 of DEFRA amended 42 U.S.C. §1395x(v)(1) by appending subparagraph (O), Petition, Appendix D, p. 35a, to require: (1) "re-evaluation" of the transferred facility at a cost no higher than the lesser of the acquisition cost to the record owner as of July 18, 1984, or the new owner's acquisition cost and (2) "recapture" of depreciation paid to the former owner utilizing the same method in place on June 1, 1984.

As to Medicaid, §2314 of DEFRA amended 42 U.S.C. §1396a(a)(13)(B), to read:

> (a) Contents. A State plan for medical assistance must –
>
> * * *
>
> (13) Provide –
>
> * * *
>
> (B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of [42 U.S.C. § 1395x(v)(1)(O).];

Thus, following DEFRA, Medicaid payments on capital-related costs could not, in the event of a change in ownership, increase more than was permissible under Medicare. At the time DEFRA was enacted, DOM's payment methodology on capital-related costs was contained in Plan Amendment 84-9 earlier approved by HCFA. Plan Amendment 84-9 did not utilize Medicare methods or reimburse at Medicare levels. By letter dated August 30, 1984, HCFA advised DOM of DEFRA and to evaluate Plan Amendment 84-9 " . . . in view of this legislative change to ensure your plan does not result in capital payments that might exceed the new requirements." (R. Vol. 2, p. 538).[1]

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[1] Cites are to the Fifth Circuit Record (R.) and Record Excerpts (R.E.).

Following such review, DOM concluded that Plan Amendment 84-9 would not comply with DEFRA and drafted a new plan amendment, designated Plan Amendment 84-36, which was transmitted to the HCFA Regional Office on November 8, 1984 (R.E., Tab. V, pp. 2-3). Plan Amendment 84-36 provided for two changes, both of which were substantially similar to the Medicare changes required by DEFRA. First, Plan Amendment 84-36 modified DOM's "re-evaluation of assets" formula. Under Plan Amendment 84-9, the allowable value of a nursing home to the new owner was generally the lesser of the purchase price, the fair market value, or the sum of historical depreciable basis prior to sale and a variable portion of the difference between that basis and the home's fair market value. Plan Amendment 84-36, like the new Medicare method, restricted the new owner's value to his acquisition cost or that of the record owner as of July 18, 1984. Moreover, Plan Amendment 84-36, unlike Medicare methodology, contained a few extra provisions to ensure that payments did not exceed the new requirements such as a provision that, in determining a new owner's interest expense allowance, precluded the new owner from treating as indebtedness any amount greater than that of the former owner.[2] Second, Plan Amendment 84-36 changed the "recapture of depreciation" provisions

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[2] In 1985, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA), effective October 1, 1985. COBRA's provision for Medicaid re-evaluation of assets was less restrictive than DEFRA and allowed for upward re-evaluation of assets up to the COBRA limit. COBRA was not a federally mandated change and DOM did not amend the state plan to adopt COBRA, retaining instead the DEFRA limits. Petition, Appendix N, p. 88a. COBRA is not, of course, relevant to petitioner's procedural challenge to Plan Amendment 84-36.

of Plan Amendment 84-9 by adopting the exact method that DEFRA mandated for Medicare.

After review, the HCFA Regional Office, on November 15, 1984, forwarded proposed Plan Amendment 84-36 to the HCFA Central Office, where the amendment was reviewed by HCFA officials, including Bernard J. Truffer, Chief of the Special Payment Programs Branch, whose duties include " . . . review and analysis of amendments to State's Medicaid plans . . . to determine whether they comply with Federal statutory and regulatory requirements." (R.E., Tab V, p. 1). Subsequently, the HCFA Central Office issued a Memorandum to the HCFA Regional Office dated December 13, 1987, which "[I]n addition to providing technical comment on the State's proposed amendment . . . advised the Regional Office to request from the State the assurances and related information required by 42 C.F.R. 447.253 for 'significant' plan amendments." (R.E., Tab V, p. 3). By letter dated December 27, 1984, Petition, Appendix I, p. 62a, the HCFA Regional Office notified DOM of the comments and requested the assurances. DOM responded with a letter to the HCFA Regional Office dated February 26, 1985, containing the assurances, among which was that "[P]ublic notice is not required as the change is to bring the State in compliance as a result of statutory change." Petition, Appendix J, pp. 66a-67a. The HCFA Regional Office transmitted DOM's response to the HCFA Central Office by Memorandum dated March 5, 1985. According to Chief Truffer of the HCFA Central Office, "[T]he State's response addressed the concerns raised in the initial review and included the assurances and related information required for approval" and Plan Amendment 84-36 was approved by

HCFA on May 1, 1985, effective October 1, 1984. (R. E., Tab V, p. 4).

Generally, 42 C.F.R. §447.205(a) requires public notice of any significant proposed change in a state Medicaid Plan. However 42 C.F.R. 447.205(b)(1) provides that such notice is not required if "[T]he change is being made to conform to Medicare methods or levels of reimbursement." While recognizing that Plan Amendment 84-36 was a significant change from Plan Amendment 84-9, DOM did not provide public notice of Plan Amendment 84-36 pursuant to 42 C.F.R. §447.205(a). Instead, DOM relied on the advice of HCFA officials, including Chief Truffer, that the proposed amendment fell within the exception authority of 42 C.F.R. §447.205(b)(1). Chief Truffer, the federal HCFA official charged with the duty " . . . to determine whether they (state plan amendments) comply with Federal statutory and regulatory requirements", testified by Affidavit: "I do not believe the State of Mississippi was obligated to provide public notice of its amendment . . . I continue to believe that public notice of the proposed amendment was not required . . . " (R.E., Tab V, pp. 1, 4-5).[3] Mr. Billy Simmons, Director of DOM at

[3] Petitioner implies that after the commencement of this litigation, HCFA advised DOM that Plan Amendment 84-36 had required public notice pursuant to 42 C.F.R. §447.205(a). Petition, pp. 9-10. The cited source for such implication is a letter from Chief Truffer. However, the record is clear that Chief Truffer before and after litigation was of the opinion that such notice was not required and consistently advised DOM of such opinion. At trial, Petitioner's expert witness acknowledged Chief Truffer's consistent opinion and simply expressed disagreement with such opinion. R., Vol. 7, pp. 32-34. Interestingly, Petitioner implies that "HCFA" advised DOM that

(Continued on following page)

the time Plan Amendment 84-36 was drafted and approved, testified by Affidavit as follows (R. Vol 3, p. 765):

> The Division of Medicaid was advised by the federal agency at the time the state submitted its amended Plan, Transmittal No. 84-36 . . . that we were not required to publish notice. We have since then been advised on several occasions by the federal agency, including Bernard Truffer in the Central Office of HCFA, that public notice was not required . . . Mr. Truffer specifically advised that it was their (HCFA's) position that the *exception authority* under 42 C.F.R. §447.205(b)(1) covered the public notice requirement. (Emphasis in Affidavit)

Although public notice of Plan Amendment 84-36 was not published pursuant to 42 C.F.R. §447.205(a), the petitioner had extensive actual notice of the passage of DEFRA and DOM's efforts to comply with DEFRA through Plan Amendment 84-36. (R. Vol. 3, pp. 919-935). Moreover, upon approval by HCFA of Plan Amendment 84-36, DOM filed the amendment for public notice and as a public record with the Mississippi Secretary of State pursuant to the Mississippi Administrative Procedures Act, Miss. Code Ann. 1972, §§25-43-1 et seq. (R., Vol. 3, pp. 913-915). Further, petitioner was not harmed by any alleged lack of notice. The record evidence is unrefuted,

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public notice was required and cites Chief Truffer for such implication. On all other occasions in the District Court and Fifth Circuit, Petitioner has argued that Chief Truffer's statements don't represent HCFA policy.

and both the District Court and Court of Appeals recognized, that petitioner was paid more under Plan Amendment 84-36 than the maximum allowable under DEFRA. Petition, Appendix A, p. 8a; Appendix C, p. 32a.

Some years later, Petitioner along with the Independent Nursing Home Association, filed this action against DOM in the District Court challenging approval and implementation of Plan Amendment 84-36 for alleged failure to comply with 42 C.F.R. §447.205(a).[4] The District Court ordered joinder of HCFA as a necessary party

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[4] Although not conceding any legal requirement to do so, DOM in 1987 submitted to HCFA proposed Plan Amendment 87-8 which contains all of the substantive provisions of Plan Amendment 84-36 and published notice pursuant to 42 C.F.R. §447.205(a) to eliminate, at least prospectively, any federal procedural challenge. HCFA approved Plan Amendment 87-8 on July 7, 1987, effective April 1, 1987. This action challenges only Plan Amendment 84-36, effective from October 1, 1984 to April 1, 1987. Petitioner has successfully challenged Plan Amendment 87-8 in a lower state court and an appeal from that court is presently before the Mississippi Supreme Court. The lower court invalidated Plan Amendment 87-8 on the basis of a state law that precludes a change in the state Medicaid rates or payments from those in effect on July 1, 1986, absent state legislative approval. The state court reasoned that since the Federal District Court had invalidated Plan Amendment 84-36, those state Medicaid rates or payments were not legally in effect on July 1, 1986, and that DOM was without legal authority, under state law, to promulgate Plan Amendment 87-8 which contained the substantive provisions of Plan Amendment 84-36. Thus, while this federal action only involves Plan Amendment 84-36, the action substantively impacts on Plan Amendment 87-8.

defendant.[5] The District Court granted petitioner's motion for summary judgment and enjoined enforcement of Plan Amendment 84-36. The District Court misapprehended the evidence and erroneously concluded that both the "re-evaluation" and "recapture" provisions of Plan Amendment 84-36 were more restrictive than the Medicare requirements set forth under DEFRA. The recapture provisions of Plan Amendment 84-36 are an exact duplication of the DEFRA Medicare provisions as acknowledged by petitioner's expert witness, Dr. Deane: "I must say the recapture part in itself is a duplication of the Medicare recapture." (R. Vol. 7, pp. 38-39). As to re-evaluation of assets, Plan Amendment 84-36 duplicated Medicare provisions for determining base value and while containing some provisions unlike Medicare methods for determining payment on the base, nevertheless, reimbursed providers in excess of the levels

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[5] Petitioner suggests that since HCFA did not file a separate appeal, HCFA agreed that public notice was required. To the contrary, HCFA's consistent position remains that regulatory public notice of Plan Amendment 84-36 was not required. Such position was, of course, the very reason for HCFA's joinder in the District Court as a party defendant. In that Court, HCFA filed a Motion To Dismiss or in the alternative, for Summary Judgment, fully and completely supporting DOM. (R. Vol. 3, pp. 1050-1096) The HCFA Memorandum Brief accompanying such Motion perhaps best explains why HCFA did not subsequently file a separate appeal: " . . . (federal law) envisions that reimbursement disputes will be resolved primarily at the state level, between the state and its providers, without the intervention of the federal government", Memorandum Brief, p. 10. Obviously content with DOM's presentation in the District Court and content to have DOM present the appeal, HCFA did not file a separate appeal.

permitted under Medicare.[6] Petition, Appendix L, pp. 77-78; Appendix N, p. 89. The Court of Appeals correctly found that Plan Amendment 84-36 was the functional equivalent of the Medicare provisions of DEFRA. Petition, Appendix A, p. 8a.

ARGUMENT

REASONS FOR NOT GRANTING THE WRIT

This case does not present any federal or state constitutional or statutory questions. Further, no question is presented upon which there is a conflict in the courts of appeals or the district courts. Moreover, the case does not present an important question of federal law. Instead, the sole question presented involves more of a question of fact than of law. The Fifth Circuit found that Plan Amendment 84-36 was the functional equivalent of the DEFRA Medicare provisions, thus falling within the ambit of 42 C.F.R. §447.205(b)(1). Such a question is not the type appropriate for review on certiorari by this Court. *U.S. v. ITT Continental Baking Co.*, 420 U.S. 223, 226-227, n. 2, 43 L. Ed. 2d 148, 155-156, n. 2, 95 S. Ct. 926 (1974); *NLRB v. Pittsburgh Steamship Co.*, 340 U.S. 498, 95 L. Ed. 479, 71 S. Ct. 453 (1951); *NLRB v. Waterman S.S. Corp.*, 309 U.S. 206, 84 L. Ed. 704, 60 S. Ct. 493, reh. den. 309 U.S. 696, 84 L. Ed. 1036, 60 S. Ct. 611 (1940); *General Talking Pictures Corp.*

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[6] The overpayment was due to DOM's method of computing the reimbursement following a change in ownership. Petition, Appendix L, pp. 77-78; Appendix N, p. 89a. The Court of Appeals held that reimbursement to HCFA of the overpayment was required. Petition, Appendix A, p. 8a, n. 3.

v. Western Electric Co., 304 U.S. 175, 82 L. Ed. 1273, 58 S. Ct. 849 (1938); *United States v. Johnston*, 268 U.S. 220, 69 L. Ed. 925, 45 S. Ct. 496 (1925).

Petitioner argues that the Fifth Circuit's opinion establishes a dangerous precedent that will allow states to circumvent the public notice requirements of 42 C.F.R. §447.205(a). Such argument is without merit. First, petitioner suggests that the Fifth Circuit established, as a rule of law, that a state plan which provides for payments in excess of DEFRA Medicare limits meets the exception authority of 42 C.F.R. §447.205(b)(1). Petitioner's argument is particularly ironic, since even if the Fifth Circuit had established such a rule of law, petitioner and others similarly situated would benefit from a state Medicaid plan that allowed such excess payments and could scarcely complain of lack of public notice. Further, petitioner's argument overlooks the fact that the Fifth Circuit's opinion was based on a factual determination of functional equivalency reached after a careful analysis of the provisions of Plan Amendment 84-36 and those of Medicare under DEFRA. Moreover, the Fifth Circuit held that reimbursement to HCFA of the excess payments was required. Petition, Appendix A, p. 8a, n. 3. Second, petitioner suggests that the Fifth Circuit placed undue emphasis on effect after implementation of the plan and that such action may encourage states to adopt and implement plans without notice under a "wait and see" approach. Again, such argument overlooks the very careful scrutiny given by the Fifth Circuit to the provisions of Plan Amendment 84-36 in comparison to those of Medicare under DEFRA. Further, states could not afford to take the gamble with a "wait and see" approach, given

the loss of substantial federal subsidies that would necessarily follow if the plan were subsequently found not to comply with the public notice requirements. Third, petitioner suggests that the Fifth Circuit placed improper reliance on DOM's intent in adopting Plan Amendment 84-36. Petition, p. 15. While the Fifth Circuit's observations on intent were more in the nature of dictum, the language of 42 C.F.R. §447.205(b)(1) is clearly subject to an interpretation that intent is a relevant factor. However, that was not the basis of the Fifth Circuit's opinion, which found that in addition to intent, Plan Amendment 84-36 was, in fact, the functional equivalent of the Medicare provisions under DEFRA.

Petitioner's policy arguments all overlook the fact that all proposed state plan amendments are subject to review by HCFA and ultimately, by the courts, for strict compliance with federal statutory and regulatory requirements. 42 U.S.C. §1396c; 42 C.F.R. §430.35. Public notice of proposed state plan amendments is generally required by the HCFA regulation, 42 C.F.R. §447.205(a), except in those limited factual circumstances, such as in the present case, that are exempt by 42 C.F.R. §447.205(b).

As a final alleged reason for granting the Petition, petitioner argues that federal law in effect on June 1, 1984, did not provide for a specific method for recapture of depreciation and that Plan Amendment 84-9 would have met the alleged general recapture requirement. Petition, pp. 17-18. First, *Mercy Community Hospital v. Heckler*, 781 F. 2d 1552 (11th Cir. 1986), the case cited by petitioner, does not support such argument. In that case, the Court considered a sale involving Medicare recapture occurring

on August 18, 1978, which was prior to the 1979 amendment to the federal Medicare recapture regulation. While deciding the case on the basis of the federal Medicare regulation in effect prior to the 1979 amendment, that Court noted that the purpose of the 1979 amendment was to provide specific Medicare rules and procedures, 781 F. 2d 1552, 1556, n. 5. Petitioner further suggests that DEFRA required that states use the Medicaid method in effect on June 1, 1984. Petition, p. 17. However, DEFRA amended Medicare law to require use of the Medicare recapture method in place on June 1, 1984. Petition, Appendix D, 42 U.S.C. §1395x(v)(1)(O)(ii). HCFA interprets DEFRA to require states to " . . . recapture any Medicaid paid depreciation in accordance with the Medicare principles for recapture of depreciation." Petition, Appendix N, p. 85a. Whether so required or not, DOM's "recapture" provisions under Plan Amendment 84-36 unquestionably duplicate Medicare's "recapture" provisions and thus, ipso facto, "conform to Medicare methods or levels of reimbursement" within 42 C.F.R. §447.205(b)(1).

CONCLUSION

This case does not present a federal or state constitutional or statutory question or a question on which there is a conflict in the courts of appeals or the district courts or an important question of federal law which this Court should now settle. Respondent respectfully submits that the Court should deny the Petition For Writ Of Certiorari.

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